King County

Department of
Community and Human Services

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FINAL PROCUREMENT PLAN
Veterans and Human Services Levy: 3.2 & 3.3
3.2: Invest in training in trauma sensitive services and PTSD treatment
3.3: Train behavioral health providers to use evidence-based practices for PTSD

1. Goal (Overarching Investment Strategy)

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of increasing access to behavioral health services (page 22 of the SIP).

2. Objective (Specific Investment Strategy)

Expand behavioral health services through primary care and other providers: Invest in training in trauma sensitive services and Post Traumatic Stress Disorder (PTSD) treatment (page 22 of SIP), and train behavioral health providers to use evidence-based practices for PTSD (page 23 of SIP).

3. Population Focus

This procurement plan will focus on training two population groups. The first group will be primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing providers who are providing supportive services. The second group will be jails, schools and social service programs. Priority for training will be those providers who serve a significant number of veterans; family members of veterans and military personnel, and school age children of veterans and military personnel.

These providers will become PTSD and trauma-informed and better equipped to assist and treat veterans, military personnel and their families, people with histories of homelessness, individuals and families who have experienced domestic violence or physical or emotional abuse, and individuals who have been incarcerated.

4. Need and Population to be Served

Veterans, Military Personnel and their Families

In 2004, there were more than 147,000 civilian veterans living in King County.[1] Of this number, 40 percent are Vietnam veterans and 16 percent are Gulf War veterans. It is also

[1] 2004 American Community Survey, U.S. Census Bureau

estimated that as many as 30 percent of homeless persons in King County are veterans.[2] Also, the 2000 census tract data identified high concentrations of traditionally defined veterans in and around downtown Seattle, Renton, Auburn, Kenmore, Kent and Crossroads areas. Each of these communities had one or more census tracts with a veteran's populations numbering 259-628.

In July of 2006 the American Psychological Association (APA) President, Dr. Gerald Koocher, was asked to establish the Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. One of the charges of this Task Force was to identify the psychological risks and mental health-related service needs of military members and their families during and after deployment(s). The Task Force found that "there is a shortage of professionals specifically trained in the nuances of military life," and "another complex and challenging task is how to modify the military culture so that mental health services are more accepted and less stigmatized." The Task Force goes on to state that "even if providers were available and seeking treatment was deemed acceptable, appropriate mental health services are often not accessible."

The Presidential Task Force on Military Deployment Services for Youth, Families and Service Members made many recommendations for further development. Of interest for this procurement plan are the following:

- Further, mental health services through the deployment cycle should incorporate prevention and intervention strategies designed to help families.[3]
- Training and education regarding the unique needs of service members and their families who are faced with deployment must be on-going for all mental health service providers (military and civilian) who treat these populations.[4]

A study conducted in the King County Jail by the Seattle VA Medical Center's Addictions Treatment Unit[5] found that 39 percent of those measured had PTSD coupled with a substance abuse problem. An accurate measure of local non-veteran substance abusers who have been diagnosed with PTSD is not available at this time; however, national studies clearly support its presence and reiterate the need for specialized treatment.[6] Evidence also suggests that untreated PTSD is a major contributor to crime which supports the substance abuse and used to self medicate.

A survey conducted by the Pentagon in 2005 found that a higher percentage of National Guard and Reserve troops have had health issues than those in active-duty forces. Forty-seven percent of National Guard troops and 45 percent of reservists required some kind of medical or mental health care last year from the VA, vs. 29 percent of active-duty troops.

[2] 2004 One Night Count of Homeless People
[3] 2007 The Psychological needs of U.S. Military Services members and their families: A Preliminary Report
[4] 2007 The Psychological needs of U.S. Military Service members and their families: A Preliminary Report
[5] 2001, Psychiatric Services Vol. 52 No. 7
[6] Trauma and Substance Abuse, Ovimette/Brown. American Psychological Association, 2003

This year, 30 percent to 35 percent of Guard and Reserve troops needed health referrals, compared with 25 percent of active-duty military personnel.[7]
Recently, many newspapers, medical journals and news articles from the armed forces publications have reported a growing number of U.S. troops in combat from Iraq and Afghanistan are suffering brain damage as a result of explosions. It's a type of injury some military doctors say has become the signature wound of the Iraq war. Known as traumatic brain injury, or TBI, the wound is of the sort that many soldiers in previous wars never lived long enough to suffer. The explosions often cause brain damage similar to "shaken-baby syndrome," says Warren Lux, a neurologist at Walter Reed Army Medical Center in Washington.

Among surviving soldiers wounded in combat in Iraq and Afghanistan, TBI appears to account for a larger proportion of casualties than it has in other recent U.S. wars. According to the Joint Theater Trauma Registry, compiled by the U.S. Army Institute of Surgical Research, 22 percent of the wounded soldiers from these conflicts who have passed through the military's Landstuhl Regional Medical Center in Germany had injuries to the head, face, or neck. This percentage can serve as a rough estimate of the fraction who have TBI, according to Deborah L. Warden, a neurologist and psychiatrist at Walter Reed Army Medical Center who is the national director of the Defense and Veterans Brain Injury Center (DVBIC). Warden said the true proportion is probably higher, since some cases of closed brain injury are not diagnosed promptly.

Soldiers with TBI often have symptoms and findings affecting several areas of brain function. Headaches, sleep disturbances, and sensitivity to light and noise are common symptoms. Cognitive changes, diagnosed on mental-status examination or through neuropsychological testing, may include disturbances in attention, memory, or language, as well as delayed reaction time during problem solving. Often, the most troubling symptoms are behavioral ones: mood changes, depression, anxiety, impulsiveness, emotional outbursts, or inappropriate laughter. Some symptoms of TBI overlap with those of post-traumatic stress disorder.

The trans-generational affects of trauma are the residual impacts of the soldier's war trauma upon his or her family members. The VA reports that of the 1.3 million active duty forces, there are 1.8 million family members stateside; of the 829,000 soldiers in the reserve component, there are 1.1 million family members at home. Current deployments of military personnel can range from 12-18 months and the impact on both the soldier and the family begins even before deployment. When the soldier returns home from service in a combat zone, there is an increased risk of substance abuse, domestic violence, family instability, with negative implications for children. The Washington State Department of Veterans Affairs PTSD Program in conjunction with the University of California Los Angeles and Madigan Army Hospital is conducting research that is examining the impact of war zone deployment on school aged children (ages 6-12) among the National Guard and active duty components (Schumacher, 2007).

[7] http://www.usatoday.com/news/world/iraq/2005-10-18-troops-stress-side_x.htm

In 2005, Army Col. Charles Hoge, Chief of Psychiatry and Behavior Services, Walter Reed Army Institute of Research told a House subcommittee that surveys show 19 percent to 21 percent of troops who have returned from combat deployments meet the criteria for PTSD, depression or anxiety.[8]

According to *both civilian* and the Defense Department's (DoD) Mental Health Task Force, providers of mental health care within DoD are not "sufficiently accessible" to military personnel and are inadequately trained. Licensed psychologists in military settings are leaving at a far faster rate than they are being replaced. Many have left because they could not handle the inherent stress of treating combat exposed soldiers, and as a result of extreme high demand for services. Inexperienced counselors were found to be using therapies better suited for substance abuse or marriage counseling. Hoge et al (2005) also found stigma associated with mental health care, which affected those needing care the most, created barriers to mental health care. An extension of this phenomenon has been the observation that upon discharge those most needing care are again least likely to obtain services once home. If they are in the National Guard or military reserves, their avoidance is complicated by their continued fears that their military careers will be harmed if they seek help. Often, a cascade of mental health and social problems must overtake and force these veterans to seek help.

A report commissioned by Defense Secretary Robert M. Gates found similar problems: "There is not a coordinated effort to provide the training required to identify and treat these non-visible injuries, nor adequate research in order to develop the required training and refine the treatment plans."

The SIP recognized that one of the greatest unmet service needs was the recognition and treatment of trauma and post-traumatic stress disorder. At the time the SIP was written, information regarding the relationship between traumatic brain injury (TBI) and PTSD was not as available. Because current research shows that some of the TBI symptoms overlap with those of post-traumatic stress disorder, this procurement plan proposes to include training regarding TBI behavioral symptoms such as: mood changes, depression, anxiety, impulsiveness, emotional outbursts, or inappropriate laughter.

The SIP recommends using Levy funds to raise awareness and to train primary care providers, behavioral health providers in mental health and substance abuse systems for the population groups mentioned above (veterans, school age children of veterans, people with histories of homelessness, etc.).

Other Persons in Need

The SIP also sets aside funding for training in the recognition and treatment of trauma and post-traumatic stress disorder to those providers who serve vulnerable individuals and families who are experiencing difficult life circumstances. These circumstances include mental illnesses and/or other chronic health conditions, problems with drug use or addiction, periodic or long-term homelessness, poverty, and domestic violence.

[8] http://www.veteransforamerica.org/ArticleID/7942

Public Health-Seattle & King County's Health Care for the Homeless Network (HCHN) contracts with community agencies to improve access and provide services for homeless and formerly homeless people. In 2006, a total of 21,438 persons were served by HCHN contractors and public health centers. Of this total, 31 percent has at least one mental health diagnosis and/or chemical dependency diagnosis.

The Urban Institute, in conjunction with the National Survey of Homeless Assistance Providers and Clients (NSHAPC) done in 1996, projected that: Each year, 2.3 million to 3.5 million people experience homelessness in America.

The 27th annual One Night Count of people who are homeless in King County took place during the night of January 25-26, 2007. Organized by the Seattle/King County Coalition on Homelessness (SKCCH) and Operation Nightwatch, hundreds of volunteers conducted a systematic "street count" of people without shelter. They counted in twelve King County cities and unincorporated areas between 2:00 a.m. and 5:00 a.m. At least, 7,839 people were homeless in King County on this winter night in 2007. This represents the minimum number of people homeless on that particular night. National research suggests that at least three times that many people will be homeless in King County over the course of a year. (2007 Annual One Night Count, Report Prepared by Seattle/King County Coalition on Homelessness)

Persons that are homeless also have a disproportionately high level of trauma/PTSD. A global percentage of the problem is estimated between 40 – 60 percent for trauma/PTSD typically the catalyst for a person becoming homeless (North, Smith, 1992).

Sexual assault is the most under-reported crime, according to the National Center for Victims of Crime (Kilpatrick, et al, 1992). Approximately 16 percent of sexual assaults are reported to law enforcement authorities. During the past 20 years, researchers have documented the widespread problem of rape trauma following sexual assault. Sexual assault causes severe psychological distress and long-term physical health problems. Sixty-six percent of victims display symptoms of PTSD referred to as rape trauma. Ninety percent of sexual assault victims experience the onset of PTSD within one month of the assault. One-third of victims of sexual assault display symptoms more than six months later.

Finally, the state-funded General Assistance-Unemployable (GA-U) Program eligibility is restricted to low income people who are physically and/or mentally incapacitated and unemployable for more than 90 days. Many of the GA-U clients are challenged by poverty, physical illness, mental and substance abuse issues, and lack of housing. In King County, there are approximately 2,500 individuals who may be eligible for time-limited GA-U benefits.[9] State data also shows that around 45 percent of this population has an identified mental health issue.[10]

[9] Verbal Communication with Betsy Jones, Community Health Plan consultant to GA-V Pilot, August 2007
[10] Bennet, Amandalei, "GA-V Managed Care Pilot: Report to the Legislature." Health and Recovery Services Administration, Division of Program Support Office of Care Coordination. Washington State DSHS, January 2006.

The populations listed above are considered as experiencing traumatic events or at a minimum experiencing difficult life circumstances. The SIP requires that Levy funds "can be invested in 1) raising awareness of trauma issued and the skills needed to address them, and 2) to support the creation of trauma-informed and trauma sensitive programs across jails, courts, emergency services, schools, social services, primary care, and housing programs." (page 22 of SIP)

5. Funds Available

First, the SIP establishes funding for training in trauma sensitive services and PTSD treatment:

	2007 Funds	Annualized, 2208-2011
Veterans Levy	$22,500	$22,500
Human Services Levy	$52,500	$52,500
TOTAL	**$75,000**	**$75,000**

The SIP proposed $22,500 from the Veterans Levy and $52,500 from the Human Services Levy annually to raise awareness and support training trauma sensitive services and PTSD treatment. In addition, this procurement plan proposes that $22,500 in 2007 Veteran Levy and $52,500 from the Human Services Levy funds be carried forward and divided over the remaining four years of the Levy.

	Annualized Funds + 2007 Carry-Forward
Veterans Levy	$28,125
Human Services Levy	$65,625
Annual Funding, 2008-2011	**$93,750**

Secondly, the SIP established funding to train behavioral health providers to use evidence-based practices for PTSD. The SIP recommends training primary care providers, behavioral health providers in the mental health and substance abuse systems and other service systems to effectively identify and address trauma and post-traumatic stress disorder in both veteran and non-veteran populations.

	2007 Funds	Annualized, 2208-2011
Veterans Levy	$250,000	$250,000

The SIP proposed $250,000 annually to train behavioral health providers to use evidence-based practices for PTSD. In addition, this procurement plan proposes that $250,000 in 2007 funds be carried forward and divided over the remaining four years of the Levy.

	Annualized Funds + 2007 Carry-Forward
Veterans Levy	$312,500
Annual Funding, 2008-2011	**$312,500**

6. Geographical Coverage

This procurement plan focuses on training primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing providers who are providing supportive services. The second group will be jails, schools and social service programs. Priority for training will be those providers who serve a significant number of veterans; family members of veterans and military personnel, and school age children of veterans and military personnel. Location for these trainings will likely be in Seattle, South King County and East King County.

The consultant (described in section 8 below) will be required to identify where the greatest concentration of veterans, military personnel and their families reside. He/she will also be required to gather demographic information from those agencies who serve veterans and military personnel such as the Washington Department of Veterans Affairs, VA Medical Center, Washington National Guard, U.S. Army and others. He/she will also meet with staff from the King County Veterans Program and the Community Services Division (CSD) who will assist in identifying who is currently serving veterans and their families. Data is currently available through CSD's Contract Reporting database which can provide the names of those agencies which serve the largest numbers of veterans and their families. In addition, there are other programs within the Department of Community and Human Services (Mental Health, Chemical Abuse Dependency Division) and CSD (Women's Program, Aging Program, Youth and Family Services Association) who can assist in identifying where the target populations mentioned in Section 4 above reside. Finally, the King County Children and Family Commission will also be asked to work with the consultant to identify agencies, schools and community providers who potentially serve the target populations mentioned in this procurement plan. Those with the largest number of veterans, military personnel and their families will be served first.

7. Evidence-based or best practice information

A wealth of scientific information exists on trauma, PTSD, and its co-occurring variants, some of the current approaches available include individual therapy (Cognitive Behavioral Therapy, and Cognitive Process Therapy), therapeutic groups, case management, medication management, and skills development.

Historically, the field of traumatology has also had to evolve treatment approaches and therapist attitudes, perspectives, and skills so as to manage symptoms found within combat forces that go beyond the diagnoses of PTSD. These problems occur when soldiers, sailors,

and airmen are forced to kill others, sometimes civilians, women, and children at very close range. These troubling experiences go far beyond typical PTSD reactions, and involve all of the combatant's senses, definitions of self, entitlement to be alive, legitimacy of social membership, and a host of other personal, spiritual, and societal issues not often considered in the training and practice experiences of the majority of therapists. This often precipitates a more complex presentation of PTSD.

Though this list of services utilized is not all inclusive, it would be incumbent upon this procurement plan to provide a variety of promising practices including an extensive review of current evidence-based practices and "centers of excellence," such as Washington State University in Pullman and other programs which may show improvement with clients suffering from trauma and PTSD. Creativity and a basic understanding of PTSD are paramount in promoting and furthering development of innovative approaches that work.

In addition, it is common for veterans to present co-occurring disorders such as depression, anxiety disorders, panic, substance abuse, and/or addiction. Matching the best approach with the individual is very challenging and demands innovative approaches. Groups such as persons who are or have been incarcerated, homeless, suffering from mental health or substance abuse problems have disproportionate rates of PTSD and are in need of access to not only methods that are proven but new and innovated approaches applicable to the diverse nature of veterans and their families. Again the key to influencing this is the strength of the clinical relationship, the knowledge base of the clinician, and his/her ability to apply this within the clinical relationship.

The purpose of this procurement plan is not to advance one particular model as universal, but to identify all options, encourage appropriate application with the individual client, and to stimulate participants to apply this new knowledge to better serve persons with the appropriate and effective care.

8. Program Strategy Description

The primary goal of this procurement plan is to raise awareness and skills and support the creation of trauma-informed and trauma-sensitive programs across systems to minimize the effects and consequences of trauma/PTSD on veterans and their families.

The secondary goal is to raise awareness that trauma/PTSD also affects people with histories of homelessness, individuals and families who have experienced domestic violence or physical or emotional abuse and individuals who have been incarcerated.

In order to accomplish the goals mentioned above, this procurement plan recommends the hiring of a consultant and a "team" of trainers to create curriculum(s), develop an effective training format and deliver the training. The consultant will work with a newly formed committee who will: 1) recommend, review and assist in the development of the curriculum(s) which must include best-practices and proven models; 2) assist with the design of the training format and location(s); 3) recommend the "grouping" for training structure (page 7, Section *6. Geographical Coverage*); 4) assist in the development of a certification process for those attending the conferences and training, and 5) ensure that high quality

training is delivered. The committee and the consultant will also work with the Levy evaluator to finalize and implement the evaluation plan for this procurement plan.

The newly formed committee will consist of staff from the King County Veterans Program, the Washington State Department of Veterans Affairs, VA Medical Center's PTSD Clinic, Harborview Medical Center, other mental health/substance abuse dependency professionals, and one member from the King County Veterans Advisory Board. The Veterans Citizen Levy Oversight Board and the Regional Human Services Levy Oversight Board will have no more than four representatives to serve on this newly formed committee. Each Levy Board will have a minimum of one representative and a maximum of no more than three representatives from either of the Levy Boards.

The consultant will arrange for Continuing Education credits to be earned for all available conference/trainings. The trainings will be provided at a cost that is affordable and scholarships will be provided for those who are employed by smaller agencies who cannot help offset the cost of training participation.

The King County Veterans Program will release a Request for Proposal (RFP) to hire a consultant to develop the curriculum and training format. A separate RFP will be released to hire a team of trainers who would be responsible for providing training to social service agencies, jails and schools.

Veteran Awareness Trainings

The SIP emphasizes the need to inform and enhance the ability of community and veteran providers to respond and treat veterans, military personnel and their families. Community service providers offer a variety of services to people throughout King County; currently, however, agencies do not universally identify clients' military background as a contributing factor leading to assistance. The proposed training will address ways to identify veterans, outline the unique factors experienced by both combat and non-combat military members, and enhance information available to those who are already assisting veterans. In addition, all veterans and current U.S. military personnel will benefit from an enhanced awareness of the issues unique to military service.

Priority for these trainings will be service providers who serve large numbers of veterans, military personnel and their families. The consultant will be asked to develop a priority list based on demographics on the target population.

Trauma Trainings

The greatest single unmet service feature among veterans, their school age children, veterans with histories of homelessness, individual veterans and families who have experienced domestic violence, physical, or emotional abuse, veterans of color, women veterans, and veterans who have been incarcerated, is the recognition and skilled treatment of post-traumatic stress disorder (page 22 of SIP). Training will raise awareness of trauma issues and the skills needed to address these areas of need, as well as support the creation of trauma-informed and trauma-sensitive programs within jails, courts, emergency services, schools, social services, primary care, and housing programs. A critical component of trainings will

be a focus of the issues faced by the returning soldiers serving in the Global War on Terrorism, and their family members.

Priority for these trainings will be primary care providers, behavioral health providers in the mental health and substance abuse systems and housing providers who offer supportive services to veterans, their school age children, veterans with histories of homelessness, individual veterans and families who have experienced domestic violence, physical, or emotional abuse, veterans of color, women veterans, and veterans who have been incarcerated. Also included in this priority group for training will schools who serve significant numbers of school age children whose families suffer from homelessness.

Training Format & Curriculum
Trainings will be provided through a large conference type format held at least once a year for the next four years. Each yearly conference will highlight national and local experts in the field of trauma and PTSD. Each conference/training will have a main topic, for example, "War and its Consequences on Those Exposed." However, at each conference the following three topics, to some extent, will be addressed: 1) Military Culture; 2) Clinical Practice/Treatment Methods; and, 3) Research in the Field of Trauma and Post-Traumatic Stress.

Additional specialized training formats in more intimate settings will also be developed. An example would be specific training for those providing supportive housing to veterans or for school counselors who serve a large number of children affected by trauma/PTSD. Also, all trainings will address topics mentioned in the paragraph above regarding military culture, clinical practice and research in the field of trauma and PSTD.

Military Culture
This element will address the differences in the military services, what is expected of military personnel, the impact of serving in the military on the entire family, assimilation back into civilian life, and services available to military personnel during and after military service. In addition, this element will also focus on the impact of military culture on veterans of color and female veterans.

Clinical Practice/Treatment Methods
This element will bring information on the most effective treatment approaches and models currently used, as well as, those being developed. It will provide a chance for those entering the field to learn proven techniques and access to practitioners who have had success using them.

Research
The field of post-traumatic stress is robust with exciting and meaningful scientific information with significant implications for future services. The trainings will bring up to date information on important past studies, current research, as well as, any implications for future treatment and services.

9. Disproportionality Reduction Strategy

There is much national research which cites that a disproportionate number of veterans of color have negative life and health outcomes. In King County, 14 percent of the veteran population is comprised of veterans of color. On the other hand, 48 percent of KCVP clients are veterans of color.

The VA reports that lifetime prevalence rates for PTSD in Vietnam veterans were higher among all veterans of color samples than among self-identified Caucasian veterans. A study of Vietnam veterans found that African-American and Hispanic Vietnam veterans reported more mental health and life adjustment problems. For PTSD in particular, Hispanic male veterans had the highest prevalence rate. Race-related stressors and personal experiences of racial prejudice or stigmatization are potent risk factors for PTSD, as is bicultural identification and conflict when one ethnically identifies with civilians who suffered from the impact or abuses of war. During Vietnam, communities of color were disproportionately represented in combat theaters.

Providers who work with veterans of color need to understand the additional complications these veterans may have experienced in order to assess and treat the full range of problems faced by veterans of color.

This procurement plan is committed to the following strategies to assist in addressing the disproportionate number of veterans of color who have longer-term negative life experiences and life options as a result of their military service:

- Applicants in the RFP process will be asked to describe their strategy in addressing systemic racism through training materials developed for this procurement plan.
- Demonstrate knowledge and partnerships with culturally relevant community-based agencies.
- Provide training materials that are culturally appropriate to engage clients of color.
- Solicit feedback and recommendations from recipients of training services.
- Work with and obtain guidance from service organizations in the community which serve veterans of color.
- Undertake an education/advocacy across systems and with partners to bring attention to terms such as “disproportionality.”

10. Coordination/Partnerships and Alignment Within and Across Systems

The King County Veterans Program Coordinator and the Deputy Director of the Community Services Division have been working with the Seattle Division of the VA Puget Sound Health Care System, The Veterans Administration Regional Office, the Washington Department of Veterans Affairs, Public Health-Seattle & King County which is responsible for Strategy 3.1 *Increasing Access to behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinic*s (page 22 of SIP) and other community service providers in the development of this procurement plan. Together, this group has worked to ensure a successful training/conference series. The intent is to bridge and better connect the criminal justice system, community and mental health

systems, including substance abuse services, in order to enhance knowledge and access to veterans' services.

The King County Veterans Program believes that the better informed service providers are regarding issues facing today's veteran and their families, the better the chance that appropriate and effective services will be provided. These conferences/trainings will ultimately provide the tools for cross system collaboration and effective services for veterans, military personnel and their families that will result in positive outcomes.

11. Timeline

November & December, 2007	Present to both Levy Oversight Boards
January through March, 2008	Prepare and Release Consultant RFP
	Prepare and Release Trainer RFP
April, 2008	Select Consultant & Negotiate Contract
	Select Trainer(s) & Negotiate Contract(s)
May through August, 2008	PTSD/Trauma Oversight Committee forms
	Training curriculum developed
	Training format completed
	Media Blitz for Upcoming Training(s) begins
September, 2008	Training Begins
November, 2008	First Large Conference/Training

12. Funding/Resource Leverage

Currently the King County Veterans Program Coordinator, the Deputy Director of the Community Services Division and the Veterans and Human Services Manager have participated in discussions regarding leveraging resources with its current partners in veteran related services such as the Seattle Division of the VA Puget Sound Health Care System, Veterans Administration Regional Office, Washington Department of Veterans Affairs, and other veteran service providers. The resource leverage will be in-kind support such as consultation, planning assistance, participation in committee and workgroups as it relates to curriculum development and training. Memorandums of Agreement and Resource Sharing agreements are in the negotiation stage with the agencies listed above.

13. Outcomes

- Increase knowledge of the non-veteran service provider system to better understand the issues facing those who have served in the military and the family that deals with the aftereffects of that service.
- Increase knowledge of primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing providers who are providing supportive services to effectively identify and address trauma and post-traumatic stress disorder in both the veteran and non-veteran populations.

14. Dismantling Systemic/Structural Racism

Dismantling systemic and structural racism is a high priority and cultural awareness of how racism is experienced in the military by persons of color, will be incorporated into training in all phases.

This proposed training program will include trainers who have a clear perspective about the linkage between cultural and racism issues and the acquisition and expression of PTSD and war trauma. This would include the understanding of war trauma exposure in the field, identification with oppressed peoples who are considered the enemy, and the perceptions of veterans of color by civilians and other veterans once home. While the military has become one of the least racially biased institutions in the nation, veterans from earlier wars, and current veterans returning home, may not see the absence of racial bias in the civilian community. These differences potentially complicate recovery, improved mental health functioning, educational access, and employment. These educational efforts will include participation from communities of color in all the training phase level events.

15. Cultural Competency

The Washington State Department of Social and Health Services/Mental Health Division's Mental Health Transformation Committee has begun a specific cultural competency training effort that will improve our ability to attend to the important issues related to veteran and veterans of color status. The Mental Health Transformation Committee effort, in conjunction with Washington State University, is creating an on-line training module which will permit statewide access. This module will include training regarding the special life experiences of the disabled, people of color, alternative life orientation, and veterans. The proposed training effort will help to enhance the need for service providers and therapists to be more aware of these issues as well as those providers we contract with. The trainings will include features that give voice to the importance of multi-cultural backgrounds and the special stresses that these features introduce into the treatment process. The RFP for the consultant and the team of trainers will include questions about cultural competency and specific training. As mentioned previously, it also important to understand and recognize military culture in a similar context and training in this regard shall be specifically addressed.

A major effort in this training is to increase culturally competent veteran services which should enhance access to appropriate services for veterans and their families. As much as possible trainings will be designed to meet specific needs of veterans who are homeless and/or incarcerated, and demand special attention. Investments in training for high needs clients, complex PTSD, and transgenerational trauma will be a priority as well as properly introducing and training new and developing professionals. The nature of trauma and PTSD is complex and training should be viewed as a continuous process over time. This plan will train/inform providers across systems of veteran resources.

16. Evaluation

Evaluations of outcomes will be a significant part of this procurement plan. It is anticipated that the Levy evaluator will review and approve the evaluation plan for this procurement plan. Evaluations of established outcomes will be completed through surveys, and pre-post evaluations. Surveys and pre-post evaluations will enable us to gauge not only benefits of the training, but guide us to continuous quality improvement of methods and services.

The evaluation of improved access to services with increased culturally competence and quality treatment for veterans, military personnel and their families is a priority. Other systemic outcomes such as benefit to the mental health system, homeless providers, or substance abuse care need to be defined.

17. Provider Selection/Contracting Process

As previously identified, the initial step will be the selection of a consultant with experience in military/veteran health issues as well as curriculum development and a knowledge base in trauma/PTSD. The qualifications of this consultant must include awareness and sensitivity to all issues noted above. The consultant should be a veteran or a person who has experienced sufficient military exposure, comprehend the impact of war and homecoming, be trained and experienced in the treatment of war trauma, and have a very full knowledge of mental health treatment and the systems that deliver these services within King County and throughout the region. Also, this individual must be knowledgeable of the federal and state Departments of Veterans Affairs, and be able to work with entities in these two systems.